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ABSTRACT

In an age of increasing emphasis on accountabiltiy and evaluation of clinical practice, professionals are questioning and examining varying processes of self evaluation. This paper describes the clinical peer group model as an evaluative process which offers its members an opportunity to receive evaluative feedback and emotional support about clinical knowledge and skills, and enables all members to assess the quality and competence of their shared ideas and suggestions. The clinical peer group, consisting of counseling professionals (five women and four men), each with an average of 11 years of clinical experience, met once a week for 2 hours of open ended discussion on evaluative questions, case situations, videotapes of therapeutic performance to elicit feedback, or any consideration of professional relevance. The evaluative experiences centered around individual presentations of case materials for problem solving and group feedback in the form of ideas or suggestions to the presenter. Although the group offered an excellent source of warm cohesion and emotional support among staff, how members made evaluative judgments about data selection, assigning priority to suggestions, and interrelating feedback from various internal and external sources was not addressed by the group or made clear to observers. Future research into the role and function of clinical peer groups in terms of members' evaluative judgments is recommended. (BL)

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Clinical Peer Group Evaluation: A Descriptive Analysis[1]

1983

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Abstract

In an age of increasing emphasis on accountability and evaluation of clinical practice, more and more professionals are questioning and examining varying processes of self-evaluation. One unique example is the clinical peer group, which offers its members an opportunity to receive evaluative feedback about clinical knowledge and skills, and enables all participants to assess the quality and competence of their shared ideas and suggestions.

The following discussion is based on an exploratory case study of one peer group. The author will describe the process by which the group operates, and will include an analysis and interpretation of personal and collective decision-making processes for evaluation.

In an age when social science professionals, particularly clinical counselors and therapists, must be accountable for performance through rigorous evaluation (Bergen & Strupp, 1972, pp. 10-11; Goldiamond, et al., 1975, pp. 110-128); the author has struggled to understand different approaches used by clinicians to assess their professional competence. As a result of these inquiries, it is apparent that evaluation of psychotherapy and other forms of counseling is a complex, often subjective, and poorly understood process. Numerous individual philosophies and procedures make it difficult to discuss, or develop, standardized models for personal evaluative decision-making, including indices of client outcome plus counselor input (Levy, 1974, p. 375). As a result, different counselors cannot be compared along similar dimensions of evaluative philosophy, method, or decision-making paradigm. Not only are counselors unclear in understanding their own evaluation (Eldridge, 1979), but researchers and theoreticians have virtually ignored practitioners as direct sources of descriptive data about how the process of self-assessment actually occurs. Failure to expend the time and effort to talk with counselors, and observe their evaluative processes is a critical detour on the unexplored road to understanding evaluation:

The process of evaluation is highly complex and subjective.

> Inherently it involves a combination of basic assumptions underlying the activity being evaluated and of personal values on the part of both those whose activities are being evaluated and those who are doing the evaluation. Evaluation is a continuous social process rarely stopping to challenge these assumptions or bring the values into the open (Suchman, 1967, p. 11).

To try to unravel, therefore, some complexities surrounding evaluation, and help construct a model which begins where the practitioner is in their actual methods of assessing performance, the author has turned his attention to professional peer groups as an interesting and informative arena within which evaluation occurs.

The Peer Group as an Evaluative Medium

Although evaluation of clinical counseling can occur in the context of supervision, cousultation, inservice training, actual treatment interviews, or exclusively as a personal introspective process, the author has become interested in an often overlooked form of evaluation occurring in professional peer groups. Since this report is a description of only one such group which the author studied, the reader may be aware of other groups which are similar, or vastly different in approaching evaluation of their members. In either case, the peer group within social service agencies is an important vehicle for professional relationships among psychologists, social workers, psychiatrists or other

counseling staff, and can have significant impact in assessing effectiveness and capability on the job.

For the present discussion, evaluation in professional clinical peer groups is defined as any group activity, interpersonal relationship, or other dynamic of communication or behavior as part of the process or content (Mackey, 1980, pp. 26-27) of collective interaction, which is used by the members to evaluate professional performance and assess the quality and competence of their clinical practice. Peer group evaluation, therefore includes all dynamics of the group norms, relationship patterns or operational procedures through which individual or collective decisions about professional capability are made and supported. The selection of a group of clinical counselors or therapists for study was based exclusively on the author's professional background and research interests in delivery and evaluation of clinical counseling services. A professional clinical counselor, therefore, is considered by the author to hold a Bachelor's, Master's or Doctoral level degree from an accredited academic program in any human service profession. This college or university program, furthermore, must authorize its graduates to perform face to face diagnostic or therapeutic counseling interviews, dealing with the emotional causes or effects of psychological, social or biological human problems. The counselor bases treatment on recognized human behavioral theories, and interventive skills consist generally of developing insight, offering support, discussing alternatives for action, and working to improve psychological and social functioning and relationships of clients.

The discussion which follows will first review the literature on peer group evaluations. The author will then describe and interpret the actual process used by a selected group of professional counselors, for self-evaluation and the evaluation of each other in the context of their collective interrelationships. Special thanks goes to the Director, Clinical Supervisor and Staff of The Center for Individual and Family Services, Mansfield, Ohio who developed an innovative group approach to evaluation, and participated in the present exploratory-descriptive case study.

The Literature

Examining the literature for models or case descriptions of professional peer group evaluation yields little definitive information. The author found no specific discussion of how evaluative peer groups actually function, and very little reference to their existence as a viable process of performance assessment. Although group oriented education and learning has long been a key vehicle for professional staff development programs (Meyer, 1966, p. 197) and traditional academic classrooms, the relationships between peers which might contribute to either learning or evaluation have not been described or analyzed in detail. In situations of group supervision, evaluation or education, the dynamics of peer interrelationships as an evaluative and learning process (Birren & Woodruff, 1973, p. 321) have also not been emphasized or supported within the current literature. In social service organizations sensitive to increasing demands for evaluative accountability,

emphasis on traditional and trusted supervisory evaluative procedures may reflect skepticism about the unknown and untested utility of peer evaluation.

In focusing on clinical social service environments, group supervision or evaluation has traditionally been didactic in nature, with supervisory staff assuming major responsibility for conducting assessment, and engineering these processes by which interpersonal evaluation might have occurred (Kaplan & Sadock, 1971, pp. 788-790; Bruch, 1974, pp. 110-111). In these typical evaluative situations, any models which exist are designed to guide the supervisor's action (Ivancevich, et al., 1977, pp. 429-440; Afalom, 1975, pp. 506-509), rather than applying to relationships between professionals of equal status. In some cases, distinctions are made between supervision and consultation as separate evaluative paradigms (Zaro, et al., 1977, pp. 203-204; Edinburg, et al., 1975, p. 120), although consultative relationships do not reflect the mutual, interdependent learning and assessment to be illustrated in this report. A major component of consultation is the superior expertise of the consultant's role, which is not formally recognized in the peer group evaluative process (Kahn, 1979, p. 520).

In recent publications, the clinical literature has accelerated its consideration of self-evaluation through measurement of client behavioral outcomes (Jayaratne, 1979, pp. 18-45); but has blatantly obscured the study of other personal or interpersonal processes through which evaluation occurs (i.e., peer

relationships, supervision, etc.). Although attention to treatment outcomes is certainly one form of evaluation, it is clearly not the only avenue which counselors use to make evaluative decisions about personal competence. In fact, the author has found extremely minimal use of systematic outcome evaluation, with much more vigorous reliance on peer and other interpersonal relationships for performance assessment (Eldridge, 1979). Since peer relationships, however, have not historically been validated as effective forms of evaluation, their questionable reliability in assessing competence may help explain their absence in even the current clinical writings.

It was the literature's neglect of the topic, therefore, along with the author's interest in describing the evaluative components of peer relationships, which precipitated this current research. Although the discovery of an existing evaluative group of clinical peers was purely accidental, their participation as case study subjects provided timely data for the present investigation. As the author observed numerous group meetings, the dynamics by which evaluation occurred began to emerge, along with other questions and observations noted in the narrative which follows. A brief description of group members and their procedural format will help familiarize the reader with the research subjects. This overview will then be followed by specific descriptions and analyses of the evaluative process.

Research Participants

The group is composed of nine professional staff, with a wide range of clinical experience, treatment orientation, and individual self-evaluative need. They represent the professional disciplines of pastoral counseling, social work, nursing, psychology and psychiatry in their clinical roles within a moderate sized community mental health center. Most of these clinicians work with individuals, couples/families and groups who present a wide range of psychological and social adjustment problems in seeking agency services. Therapeutic treatment orientations among the clinicians include gestalt, behavior modification, reality therapy, systems, transactional analysis, existential and a combination of eclectic approaches.

The peer group is composed of five women and four men with an average age of thirty four. They average nearly eleven years of experience per person, with only one member having less than ten years of clinical practice. Two group members possess a bachelor's level degree, while five hold master's credentials, one has a Ph.D., and there is one M.D. represented. The officially designated supervisor of clinical services is a member of the group, although her formal supervisory and evaluative functions are not incorporated into the peer evaluative process.

Overall, the research subjects are very bright, articulate, motivated and serious minded about their cohesive evaluative group. Their high level of expertise, personal maturity and professional dedication certainly effects the quality of their relationships, and may be a significant factor in coloring the specific atmos-

phere and process of their peer group experience. The reader is reminded, therefore, to cautiously generalize findings about this group to other contexts, as individual personalities and agency environment may produce entirely different findings in other situations.

In outlining the structure of the group, membership is voluntary, although regular participation is expected after individuals commit themselves to this peer activity. Absences without good reasons (emergency patient, vacation, expressed need for "time out") might be interpreted as lack of responsibility to other members, and could lead to discussion or confrontation during a group session. Staff members not wanting to participate are not pressured, and can choose another similar group in the agency, or remain out of groups entirely with no negative implications about their motivation or staff performance. This is not a major problem, however, since all members enjoy and look forward to their group involvement. The regular weekly meeting lasts two hours with an open agenda for introduction of evaluative questions, discussion of problematic case situations, use of videotapes to elicit feedback on members' therapeutic performance, or consideration of any subject of professional relevance initiated by group participants. Most personal agendas are considered valid and appropriate for the group's attention, so concensus on "first come - first served" issues is unnecessary, unless one member requests priority consideration of a pressing evaluative need. There is no formalized leadership structure or standardized

evaluative procedure, as the group operates with a very informal and open format. The group concerns itself with its own process as well as content (Yalom, 1975, p. 122), and balances knowledge acquisition, skill development, and personal growth in its procedural orientation. The principal evaluative experiences center around two dynamics of group process: (1) individually presented agenda items, and (2) feedback contributions from the group. Each area will now be discussed and analyzed in detail in the following sections.

Individual Presentations as a Form of Self-Evaluation

The most basic evaluative process in the group is the presentation of case material by individual members, typically resulting from personal questions about the dynamics or progress of their work with clients. Staff who feel uncomfortable or uncertain about a diagnostic impression, case situation, or treatment skill relating to either single or numerous cases, may choose to share their problem with the group. Individual members are never required to present cases or questions for the group's deliberation, as their option to participate is entirely voluntary. In this regard, there is no formalized requirement for accountability, although informal group norms seem to stimulate all members to participate as individual needs arise. Professional staff are viewed in the agency as mature, growth-oriented clinicians, whose self-awareness and desire for competency encourage assertive involvement in the group evaluative process.

For members who decide to request the group's assistance, their presentations could be predicated on any of the following situations:

1. uncertainty about a theoretical or ethical principle of treatment being properly understood or applied as an interventive strategy and skill;
2. need for additional knowledge of personality characteristics or relationship dynamics for individual clients, families or groups;
3. lack of self-awareness of personal traits which negatively influence a therapeutic relationship;
4. desire to acquire information on referral sources, other service agencies, or additional treatment options to handle unmet needs of specific clients;
5. inability to resolve personal problems or conflicts felt to interfere with effective professional performance;
6. deprivation in any area of personal growth, learning, or professional progress in accord with individual developmental standards.

In addition to these problem-oriented motives for presenting to the peer group, staff also discuss successes in cases or share positive experiences to enhance everyone's learning, and receive emotional rewards for competent performance. Members in the group emphasize that peer assessment is valued equally for problem solving, as well as positive reinforcement for members' competent performance.

In analyzing the peer evaluative process, presentations in the group almost always relate to problematic interactions with clients, either within single interviews or spanning several therapeutic encounters. The group's feedback is an excellent source of data to describe and thoroughly analyze the dynamics of client functioning, as well as the characteristics of the very complex on-going treatment relationship. This is a particular strength of the group process, since a great deal of quality information or feedback can be provided to the presenter in a relatively short time period, which is also responsive to the immediacy of their clinical concerns.

Although presenters clearly focus on the nature of their clinical problems, and articulate specific questions to be answered, one problem is that they often do not delineate how the group's feedback will be used to help make personal evaluative decisions about their performance. Each presenter is able to ask for information or comments about their work, receives numerous excellent ideas and suggestions, but many do not openly discuss how the group's contributions will actually be used for evaluative judgments. This is not surprising, however, since the author had previously documented clinical practitioners' lack of awareness, and inability to specifically describe their personal processes for making evaluative decisions (Eldridge, 1979). When the author asks presenters to clarify how they plan to use group feedback, they grapple with this difficult question, but often achieve increased self-awareness and specificity in their plans, through

this examination of their decision-making process. It appears that the group can be most accurate, specific, and focused in offering evaluative feedback, therefore, if the presenter identifies (1) what decisions about competence need to be made; (2) what types of data are necessary to make these judgments, and (3) how these decisions about personal effectiveness will actually transpire.

In observing group interaction, the author noted relatively few occasions when presenters actually made conclusive, judgmental decisions about their competence during the group session. Although there are strong group norms for the presenter to seriously consider the relevance and usefulness of group feedback, there is no formal expectation or systematic process for individual decision making in the group itself. The quality of staff, and collective confidence in each other's professional competence, encourage high levels of individual initiative and responsibility in dealing with any feedback resulting from a group session. The group cohesion and mutual caring among members insures consistent, qualitative efforts to either give or receive feedback; but the group has little reliable information about the value of its feedback to presenters, and has no assurance that individual members actually use group input to help make evaluative judgments. This can become a problem in situations where some staff might choose not to use the group's collective expertise, and could conceivably neglect the evaluative process altogether. Although the author is convinced that evaluative judgments by group members do occur, the

visibility of evaluative decision making in the group would empirically confirm this, and assist in studying exactly how these decisions are made. Since the group does not require presenters to report back about the subsequent use or value of its feedback, there is no standardized way of determining the relationship between group inputs and individual determinations about effective or ineffective performance. An individual seeking feedback from the group is typically presented with an array of alternative ideas, and chooses to utilize this information in any manner which is personally suitable, and deemed appropriate to help with evaluative decisions. Although there is an implicit assumption that individuals report back to the group when problems have not been resolved, it is still difficult to insure that group contributions have actually been used, or to determine how specific suggestions have helped in evaluative decisions. This model appears to encourage the absence of negative feedback from the individual about the group's contributions, as an index of the success of the group effort - although the group pays a heavy price in not learning specifically how its input has been helpful so that successful processes can be defined, refined and retained for future use.

Considering the content of presentations, evaluative discussions characteristically involve concerns about therapeutic process, with less attention to outcome, end products, or client goal attainment (Levy, 1974, p. 375; Bloom & Block, 1977, p. 130). The group's sensitivity to competent performance during the course of treatment is paramount, and they generate considerable energy and expertise

in assessing the dynamics, operations and techniques which are the working parts of the treatment relationship. The group spends much less time with evaluative questions concerning overall successes or failures at the conclusion of treatment contracts. Cases which are completed are seldom presented to the group, in favor of more immediate concerns with cases in progress. By not focusing questions on overall successes or failures regarding treatment goals, staff solicit peer feedback without the benefit of critical outcome data for deciding long range competency. They do a good job, however, in stimulating suggestions and ideas about on-going therapeutic processes, which all group members find extremely valuable. The actual potency of members' evaluative consultations to one another, therefore, center around a critique of clinical skill and knowledge as they occur during treatment relationships. Presenters can use the group to assess their competence in demonstrating good skills and interventive methods, and as a sounding board to determine when and how specific skills or knowledge are inconsistent with ongoing case dynamics and normative theories of correct intervention. Evaluative judgments, however, about performance capability in accomplishing treatment objectives, are of questionable validity, since the group rarely addresses issues regarding overall client outcome. From a scientific standpoint, changes in therapeutic techniques based on group feedback about process, prevents the counselor from ever determining the true effect of a consistently administered independent variable (treatment intervention) on the dependent variable

(client change) at the outcome of treatment.

In addition to presentations by individual members, the group also derives evaluative benefit from the feedback or contributions offered by staff, in conjunction with these individually presented case materials. This marks an added benefit to the overall evaluative process, by capitalizing on interdependent relationships between those who present and those who respond with suggestions on other forms of evaluative contribution.

Individual Feedback Contributions as a Form of Self-Evaluation

Although each group member derives evaluative benefit from case presentations or introduction of other assessment questions, there is also mutual evaluative gain as other group members offer ideas or suggestions to the presenter. This attractive feature of the group gives all members an opportunity and expectation to develop evaluative criteria for their input into group process, and to assess competence regardless of who is presenting to the group. The staff members assess the quality of their input (feedback to presenter or comments to one another), and attempt to judge varying degrees of capability based on the following criteria applied to their contributions:

1. the degree of contribution to development of a wide range of alternatives to be considered by the group or a presenter, which often means introducing unique or different comments from those already mentioned by colleagues;

2. the contribution of ideas consistent with individual theoretical treatment orientations, and the ability to defend these suggestions if they appear inconsistent with recognized knowledge bases;

3. the ability to make connective links with previously mentioned ideas, for the group's cumulative knowledge building and logical coherence of suggestions to the presenter;

4. the maintenance of a growth-oriented attitude underlying all contributions, and personal ability to stimulate or support self-awareness or insight of other group members.

Decisions about the quality or usefulness of group contributions are mad informally, through general comments by presenters or other members as to the value of a suggestion or idea. This is usually a broad statement that a suggestion is "helpful" or that "insight is developed" as a result of someone's thoughts or ideas that are shared in the group. As noted earlier, the group does not systematically describe <u>how</u> particular contributions are helpful, so contributors may be uncertain about the nature of integration of their ideas into presenter's or colleague's decision-making processes. By hearing general affirmation of the utility of suggestions, however, the contributor validates that they have made a qualitative and competent offering and they feel good about this action. The group has not, as yet, developed a procedure to identify why and how contributions are evaluatively effective; nor do they test the validity of feedback which comes from pre-

senters, who indicate growth, change or improvement has actually occurred as a result of the group's contributions. There appears to be a wide margin within which assumptions of effective contributions are predicated on very general data about the utility of ideas or suggestions. In this case, a member's judgment about a valuable contribution they have made, is based more on subjective perceptions of the quality of their input, as opposed to empirical indices which demonstrate that a contribution has a desirable outcome for the recipient of the contribution.

Another factor complicating this process is the presenter's occasional selective attention to only those suggestions which confirm preconceived ideas. Although group members attempt to avoid this selective bias, its infrequent occurrence either boosts or lowers self-evaluative impressions, when members seem to need confirmation of their positive or negative feelings about their knowledge or skill. This has a particularly unfortunate consequence when group members feel badly about their work, and do not "hear" the positive feedback from colleagues.

The significance attached to various ideas by presenters or contributors also reflects status, so that thoughts or suggestions are sought and valued differentially, depending on the perceived quality and importance of each member's informal role in the group. This does not appear a major obstacle, however, since all members highly regard each other's competence and knowledge, and maintain a high degree of cohesion based on mutual respect and interdependence. The group is not dominated by any member, and there is a norm that all contributions are valuable in helping others, and

also for providing self-awareness and personal learning.

In analyzing the content of feedback which group members receive from one another, comments include the following: listings of alternative thoughts or behaviors for the therapist to use with clients; varying interpretations of causes of client behavior or dynamics of therapeutic relationships; analyses of obstacles to client growth or descriptions of transference phenomena, etc. The range of differing suggestions is vast, and the author is impressed with the group's ability to provide comprehensive, qualitative descriptions and analyses of almost all facets of the therapeutic process. Although presenting this wide range of alternatives is one index used by the group to gauge its competence, there is a significant gap in differentiating which ideas or suggestions are considered the best or most accurate by the collective membership. Since suggested alternatives are not ranked or otherwise prioritized by the group, individual presenters are free to subjectively judge the merit of all contributed ideas, but do not routinely benefit from the group's expertise and qualitative discrimination among various suggestions. The "expert" roles (Kahn, 1979, p. 520) characteristic of traditional superivsory relationships are absent in the peer group, which may help explain reluctance for definitive judgments about "right or wrong" contributions, which would normally come from the powerful supervisory authority. A group decision concerning the relative merits of each contribution may be one organized way to insure competence and accountability regarding the group's input. There is again,

however, no standardized process to insure that individuals will implement even the most valued group suggestions. The collegial equality and congenial climate in the group, may mitigate against judging members' contributions, and strong value positions may suggest a serious threat to the emotional support so important to the group process.

Although there are numerous other dynamic of group interaction which interplay with the evaluative process, limited space prevents their discussion here. It is important, nonetheless, for the reader to appreciate the vast complexity of evaluating competence, and to consider all evaluative situations as having numerous interactive variables whose relationship has yet to be defined and understood. The descriptions presented here are exploratory and may reflect the special characteristics of the case study group, and also the special interests of the author as observer. All practitioners are challenged, however, to examine personal or group evaluative experiences from other perspectives, to help build knowledge and skill in understanding the complex process of evaluation.

Summary and Implications

The author discussed evaluative group processes in terms of individual staff presentations to the group, and feedback from other group members in response to these presentations. Although the quality and range of questions, suggestions, and ideas is highly impressive, the process by which individual members make

decisions about their competence based on (1) their questions or (2) group responses remains undefined. It seems clear that all group members do make evaluative judgments, but how this process works in terms of data selection, prioritizing suggestions, and interrelating feedback from various internal and external sources is very confusing. In addition, the group's practice of not offering value judgments concerning the quality of individual contributions to the group, or therapeutic behavior discussed within the group, reduces its ability to capitalize on collective expertise, and places primary self-evaluative responsibility on individual subjective interpretations and optional utilization of group feedback.

The group evaluative process has its greatest impact in helping members understand and develop capability concerning their on-going relationships with clients, and provides an excellent source of warm cohesion and emotional support among staff. The group appears able to develop procedures to also help its members assess the outcomes of their therapeutic work, although up to this point they have chosen to emphasize the process rather than outcome of treatment.

The author has learned a good deal about this unique evaluative process, and suggests the case study method as a much needed research design for exploring all aspects of professional evaluative experience. The author also extends warm appreciation to the staff at The Center for Individual and Family Services for their patience, cooperation and commendable interest in research

and in their growth and development as professional clinicians. Hopefully this presentation will alert readers to the benefits of group evaluations, and heighten their desire to learn more about this important yet complex process.

Footnotes

[1]Special appreciation is extended to each of the Peer Group members for participating in the study, and helping to review the manuscript: Judy Guthrie, M.S.W.; Linwood Chamberlain, M.Div,; Melinda Movery, B.S.N.; John Jorden, M.Div., M.Ed.; Jim Sunbury, Ph.D.; Cheryl Cummins, M.A.; Georgina Hurd, M.A.; Jim Christopher, M.D.; and Gloria Miller, R.N.

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